CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
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Board of Pharmacy

Affidavit of Preceptor

To be completed by the Applicant and submitted to the preceptor:

Name of Applicant: _____

To be completed by the applicant's preceptor then sent **directly** to the Board.

I hereby certify that I, _____, License # _____, accept the responsibility of a preceptor for _____. I agree to provide the applicant with the experience outlined in the Board's Practical Experience Program. If I terminate my preceptorship agreement with the applicant, I will notify the Board in writing within 10 calendar days. I also hereby certify that I am a licensed pharmacist and have been practicing for at least two years.

SIGNATURE OF PRECEPTOR: _____

DATE: _____

Subscribed and sworn to before me this _____ day of _____ 20____.

Witness my hand and seal hereunto attached.

Notary Signature_____

(SEAL)

Send this form directly from the Preceptor to the Board of Pharmacy office at the address above.

Revised 6/2008